Michael Miller, LMFT
Client Family Information

Name:			**Date:**
Birthdate:	**Age:**	**Gender:**	**SSN:**
Address:			
Phone numbers:	**Home:**	**Work:**	**Cell:**
Occupation:		**Employer:**	
Grade Completed or in:		**School:**	
Cultural Heritage:		**Spiritual Practice:**	
Presenting Problems:			

Mental Health
Current Mental Health Providers:
Psychiatrist:
Psychiatric Medications:
Previous Mental Health Providers and Dates of Care:
Community Resources Utilized (AA, support groups, etc.):

Physical Health
Medical Conditions:
Medications for Physical Conditions:
Family Physician Name and Phone:
Drug and Food Allergies and Adverse Reactions:

Legal Issues Impacting You:

In an Emergency	**Notify:**	**Relationship:**	**Phone:**

Family	**Name***	**Date of Birth***	**Year Married**	**Year Divorced**	**Year Deceased**
Mother					
Father					
Sibling					
Sibling					
Sibling					
Spouse/Partner					
Other					
	Name	**Date of Birth**	**Resides with**	**School Attends**	**Grade**
Child					
Child					
Child					

*** Adult clients may choose to omit this identifying data.**